Senate Bill No. 228

Passed the Senate September 12, 2003

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Secretary of the Senate

Passed the Assembly September 12, 2003

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of

_____, 2003, at _____ o'clock __M.

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Private Secretary of the Governor

Corrected 9-22-03

CHAPTER _____

An act to amend Section 12813 of the Government Code, and to amend Sections 29, 110, 122, 124, 127.6, 138.1, 139.2, 139.3, 139.31, 139.4, 139.45, 4061, 4062.5, 4062.9, 4068, 4603.2, 4603.4, 4628, 5307.3, 5703, and 6401.7 of, to add Sections 77.5, 3823, 4062.01, 4604.5, 4610, 4903.05, and 5307.27 to, to repeal Sections 139, 139.1, and 5307.21 of, to repeal and add Sections 3201.7, 4600.1, 5307.1, 5307.2, and 5318 of, and to repeal, add, and repeal Section 4062 of, the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 228, Alarcon. Workers' compensation.

(1) Existing law establishes a workers' compensation system to compensate an employee for injuries sustained in the course of his or her employment. Existing law establishes, in the Department of Industrial Relations, the Commission on Health and Safety and Workers' Compensation, to conduct a continuing examination of the workers' compensation system and of the state's activities to prevent industrial injuries and occupational diseases.

This bill would require the commission, on or before July 1, 2004, to conduct a survey and evaluation of nationally recognized standards of care, including existing medical treatment utilization standards, including independent medical review, as used in other states, at the national level, and in other medical benefit systems, and to issue a report of its findings and recommendations to the Administrative Director of the Division of Workers' Compensation, on or before October 1, 2004, for purposes of the adoption of a medical treatment utilization schedule.

(2) Existing law provides that the court administrator shall hold office at the pleasure of the administrative director.

This bill, instead, would provide that the court administrator hold office for a term of 5 years.

(3) Existing law establishes the Industrial Medical Council, consisting of various types of medical practitioners, and requires the council to perform various functions and duties in connection with the provision of medical services under the workers' compensation program.

This bill would eliminate the council and would transfer many of its functions and duties to the administrative director. It would also transfer all assets and liabilities of the council, as well as funds appropriated for the support of the council in the annual Budget Act, to the Workers' Compensation Administration Revolving Fund, and would make conforming changes.

(4) Existing law provides that it is unlawful for a physician to refer a person for specified medical goods or services whether for treatment or medical-legal purposes if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral, except in prescribed circumstances. A violation of this provision is a misdemeanor.

This bill would add outpatient surgery, as defined, to the list of medical goods or services for which it is unlawful for a physician to refer a person under this provision. By creating a new crime, this bill would impose a state-mandated local program.

(5) Existing law makes it a crime for any person to make false or fraudulent statements, or take certain other actions, with respect to any claim under the workers' compensation system.

This bill would require the administrative director, in coordination with specified entities, to adopt specified protocols, if applicable, concerning medical billing and provider fraud. It would require certain parties to report claims believed to be fraudulent to the administrative director in accordance with these procedures.

(6) Existing law authorizes collective bargaining agreements between a private employer or groups of employers engaged in the aerospace and timber industries and a recognized or certified exclusive bargaining representative that establishes a dispute resolution process for workers' compensation instead of the hearing before the Workers' Compensation Appeals Board and its workers' compensation administrative law judges, or that provides for specified other alternative workers' compensation programs.

This bill would delete this authorization for employers engaged in the aerospace and timber industries, and instead would authorize labor-management agreements meeting prescribed criteria for any employer or groups of employers that meet certain requirements. By requiring certain information in connection with these provisions to be submitted by an employer or collective

bargaining representative under penalty of perjury, this bill would expand the definition of the crime of perjury, thereby imposing a state-mandated local program.

(7) Existing law requires a pharmacy that provides medicines and medical supplies that are required to cure or relieve effects of an injury covered by workers' compensation to provide the generic drug equivalent, if available, unless the prescribing physician provides otherwise in writing.

This bill would instead provide that this requirement applies to any person or entity that dispenses medicines and medical supplies to a worker to cure or relieve the effects of an injury covered by workers' compensation, but would provide that compliance with this provision is not required under specified circumstances.

(8) Existing law requires an employer to provide payment to a physician who has provided medical treatment to an injured employee as part of his or her workers' compensation benefits within 60 days after the employer receives a billing statement and other documentation, except as prescribed.

This bill would reduce this period to 45 days, except for employers that are governmental entities.

Existing law provides that any properly documented amount not paid by the employer within this 60-day period shall be increased by 10% plus interest, unless the employer takes prescribed actions.

This bill would increase the amount of this penalty from 10% to 15%, and would establish filing fees for liens filed by providers in connection with the collection of unpaid amounts.

(9) Existing law requires the administrative director to adopt rules and regulations to, among other things, require acceptance by employers of electronic claims for payment of medical services.

This bill would require that these rules and regulations relating to electronic claims for payment of medical services be adopted on or before January 1, 2005, and would also require that these rules and regulations require all employers to accept these electronic claims for payment on or before July 1, 2006.

The bill would also require that payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made by the employer within 15 working days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule.

(10) Existing law establishes procedures with respect to disputes between employers and employees regarding the compensability of the injury and the extent and scope of medical treatment for that injury. Existing law creates a presumption in certain circumstances that the treating physician of an employee, who has been predesignated by the employee, is correct.

This bill, until January 1, 2007, would establish procedures to be followed when an employer objects to a treating physician's recommendation for spinal surgery, and would revise the above presumption for treating physicians, as specified. It would also require the Commission on Health and Safety and Workers' Compensation to conduct a study of the spinal surgery second opinion procedure by June 30, 2006, and to issue a report on its findings.

(11) Existing law requires the administrative director to adopt an official medical fee schedule, which shall establish reasonable maximum fees paid for medical services provided under the workers' compensation laws. Existing law requires the administrative director to adopt by July 1, 2003, and revise no less frequently than biennially, an official pharmaceutical fee schedule. Existing law additionally provides that the administrative director has the sole authority to develop an outpatient surgery facility fee schedule for services not performed under contract.

This bill would, instead, require the administrative director to adopt and revise periodically a medical fee schedule for various services, drugs, fees, and goods, as specified, other than physician services. This bill would require that, within the limits established by the bill, the rates or fees established by the medical fee schedule be adequate to ensure a reasonable standard of services and care for injured employees, and would make conforming changes.

This bill would require the Commission on Health and Safety Workers' Compensation to contract with an independent consulting firm, to the extent permitted by state law, to perform an annual study of access to medical treatment for injured workers, and would authorize the commission to recommend to the administrative director appropriate adjustments to the official medical fee schedule.

This bill would also require the administrative director, on or before December 1, 2004, to adopt, after public hearings, a medical treatment utilization schedule, as specified.

The bill would provide that this schedule would create a rebuttable presumption that the schedule is correct on the issue of extent and scope of medical treatment of a worker's injuries. It would also provide that certain guidelines shall be presumptively correct on the issue of extent and scope of medical treatment of a worker's injuries for a specified period of time. The bill, notwithstanding the medical treatment utilization schedule and specified guidelines, would limit the number of chiropractic and physical therapy visits by an employee per industrial injury, as specified.

This bill would also require every employer to establish a utilization review process, either directly or through its insurer or entity with which an employer or insurer contracts for these services, in accordance with specified criteria, and would authorize the administrative director to assess administrative penalties for failure to meet certain requirements.

(12) Existing law authorizes the appeals board to receive specified types of information in addition to sworn testimony presented in open hearings.

This bill would include relevant portions of medical treatment protocols published by medical specialty societies among the information authorized to be received by the appeals board.

(13) Existing law requires every employer to establish, implement, and maintain an effective injury prevention program. Existing law also authorizes an employer to adopt the Model Injury and Illness Prevention Program for Non-High-Hazard Employment and the Model Injury and Illness Prevention Program for Employers in Industries with Intermittent Employment, developed by the Division of Occupational Safety and Health.

This bill would require every workers' compensation insurer to conduct a review of these injury and illness prevention programs of each of its insureds within 4 months of the commencement of the initial insurance policy term.

(14) This bill would declare that its provisions are severable.

(15) This bill would declare that its provisions would become operative only if AB 227 of the 2003–04 Regular Session is enacted and becomes operative.

(16) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 12813 of the Government Code is amended to read:

12813. The Labor and Workforce Development Agency consists of the following:

(a) Office of the Secretary of Labor and Workforce Development.

(b) Agricultural Labor Relations Board.

(c) California Workforce Investment Board.

(d) Department of Industrial Relations, including the California Apprenticeship Council, California Occupational Safety and Health Appeals Board, California Occupational Safety and Health Standards Board, Commission on Health and Safety and Workers' Compensation, Industrial Welfare Commission, State Compensation Insurance Fund, and Workers' Compensation Appeals Board.

(e) Employment Development Department, including the California Unemployment Insurance Appeals Board, and the Employment Training Panel.

SEC. 2. Section 29 of the Labor Code is amended to read:

29. ''Medical director'' means the physician appointed by the administrative director pursuant to Section 122.

SEC. 3. Section 77.5 is added to the Labor Code, to read:

77.5. (a) On or before July 1, 2004, the commission shall conduct a survey and evaluation of evidence-based, peer-reviewed, nationally recognized standards of care, including existing medical treatment utilization standards, including independent medical review, as used in other states, at the national

level, and in other medical benefit systems. The survey shall be updated periodically.

(b) On or before October 1, 2004, the commission shall issue a report of its findings and recommendations to the administrative director for purposes of the adoption of a medical treatment utilization schedule.

SEC. 4. Section 110 of the Labor Code is amended to read:

110. As used in this chapter:

(a) ''Appeals board'' means the Workers' Compensation Appeals Board. The title of a member of the board is ''commissioner.''

(b) ''Administrative director'' means the Administrative Director of the Division of Workers' Compensation.

(c) ''Division'' means the Division of Workers' Compensation.

(d) ''Medical director'' means the physician appointed by the administrative director pursuant to Section 122.

(e) ''Qualified medical evaluator'' means physicians appointed by the administrative director pursuant to Section 139.2.

(f) ''Court administrator'' means the administrator of the workers' compensation adjudicatory process at the trial level.

SEC. 5. Section 122 of the Labor Code is amended to read:

122. The administrative director shall appoint a medical director who shall possess a physician's and surgeon's certificate granted under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code. The medical director shall employ medical assistants who shall also possess physicians' and surgeons' certificates and other staff necessary to the performance of his or her duties. The salaries for the medical director and his or her assistants shall be fixed by the Department of Personnel Administration, commensurate with the salaries paid by private industry to medical directors and assistant medical directors.

SEC. 6. Section 124 of the Labor Code is amended to read:

124. (a) In administering and enforcing this division and Division 4 (commencing with Section 3200), the division shall protect the interests of injured workers who are entitled to the timely provision of compensation.

(b) Forms and notices required to be given to employees by the division shall be in English and Spanish.

SEC. 7. Section 127.6 of the Labor Code is amended to read:

127.6. (a) The administrative director shall, in consultation with the Commission on Health and Safety and Workers' Compensation, other state agencies, and researchers and research institutions with expertise in health care delivery and occupational health care service, conduct a study of medical treatment provided to workers who have sustained industrial injuries and illnesses. The study shall focus on, but not be limited to, all of the following:

(1) Factors contributing to the rising costs and utilization of medical treatment and case management in the workers' compensation system.

(2) An evaluation of case management procedures that contribute to or achieve early and sustained return to work within the employee's temporary and permanent work restrictions.

(3) Performance measures for medical services that reflect patient outcomes.

(4) Physician utilization, quality of care, and outcome measurement data.

(5) Patient satisfaction.

(b) The administrative director shall begin the study on or before July 1, 2003, and shall report and make recommendations to the Legislature based on the results of the study on or before July 1, 2004.

(c) In implementing this section, the administrative director shall ensure the confidentiality and protection of patient-specific data.

SEC. 7.5. Section 138.1 of the Labor Code is amended to read:

138.1. (a) The administrative director shall be appointed by the Governor with the advice and consent of the Senate and shall hold office at the pleasure of the Governor. He or she shall receive the salary provided for by Chapter 6 (commencing with Section 11550) of Part 1 of Division 3 of Title 2 of the Government Code.

(b) The court administrator shall be appointed by the Governor with the advice and consent of the Senate. The court administrator shall hold office for a term of five years. The court administrator shall receive the salary provided for by Chapter 6 (commencing with Section 11550) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 8. Section 139 of the Labor Code is repealed.

SEC. 9. Section 139.1 of the Labor Code is repealed.

SEC. 10. Section 139.2 of the Labor Code is amended to read:

139.2. (a) The administrative director shall appoint qualified medical evaluators in each of the respective specialties as required for the evaluation of medical-legal issues. The appointments shall be for two-year terms.

(b) The administrative director shall appoint or reappoint as a qualified medical evaluator a physician, as defined in Section 3209.3, who is licensed to practice in this state and who demonstrates that he or she meets the requirements in paragraphs (1), (2), (6), and (7), and, if the physician is a medical doctor, doctor of osteopathy, doctor of chiropractic, or a psychologist, that he or she also meets the applicable requirements in paragraph (3), (4), or (5).

(1) Prior to his or her appointment as a qualified medical evaluator, passes an examination written and administered by the administrative director for the purpose of demonstrating competence in evaluating medical-legal issues in the workers' compensation system. Physicians shall not be required to pass an additional examination as a condition of reappointment. A physician seeking appointment as a qualified medical evaluator on or after January 1, 2001, shall also complete prior to appointment, a course on disability evaluation report writing approved by the administrative director. The administrative director shall specify the curriculum to be covered by disability evaluation report writing courses, which shall include, but is not limited to, 12 or more hours of instruction.

(2) Devotes at least one-third of total practice time to providing direct medical treatment, or has served as an agreed medical evaluator on eight or more occasions in the 12 months prior to applying to be appointed as a qualified medical evaluator.

(3) Is a medical doctor or doctor of osteopathy and meets one of the following requirements:

(A) Is board certified in a specialty by a board recognized by the administrative director and either the Medical Board of California or the Osteopathic Medical Board of California.

(B) Has successfully completed a residency training program accredited by the American College of Graduate Medical Education or the osteopathic equivalent.

(C) Was an active qualified medical evaluator on June 30, 2000.

(D) Has qualifications that the administrative director and either the Medical Board of California or the Osteopathic Medical Board of California, as appropriate, both deem to be equivalent to board certification in a specialty.

(4) Is a doctor of chiropractic and meets either of the following requirements:

(A) Has completed a chiropractic postgraduate specialty program of a minimum of 300 hours taught by a school or college recognized by the administrative director, the Board of Chiropractic Examiners and the Council on Chiropractic Education.

(B) Has been certified in California workers' compensation evaluation by a provider recognized by the administrative director. The certification program shall include instruction on disability evaluation report writing that meets the standards set forth in paragraph (1).

(5) Is a psychologist and meets one of the following requirements:

(A) Is board certified in clinical psychology by a board recognized by the administrative director.

(B) Holds a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, from a university or professional school recognized by the administrative director and has not less than five years' postdoctoral experience in the diagnosis and treatment of emotional and mental disorders.

(C) Has not less than five years' postdoctoral experience in the diagnosis and treatment of emotional and mental disorders, and has served as an agreed medical evaluator on eight or more occasions prior to January 1, 1990.

(6) Does not have a conflict of interest as determined under the regulations adopted by the administrative director pursuant to subdivision (o).

(7) Meets any additional medical or professional standards adopted pursuant to paragraph (6) of subdivision (j).

(c) The administrative director shall adopt standards for appointment of physicians who are retired or who hold teaching

positions who are exceptionally well qualified to serve as a qualified medical evaluator even though they do not otherwise qualify under paragraph (2) of subdivision (b). In no event shall a physician whose full-time practice is limited to the forensic evaluation of disability be appointed as a qualified medical evaluator under this subdivision.

(d) The qualified medical evaluator, upon request, shall be reappointed if he or she meets the qualifications of subdivision (b) and meets all of the following criteria:

(1) Is in compliance with all applicable regulations and evaluation guidelines adopted by the administrative director.

(2) Has not had more than five of his or her evaluations that were considered by a workers' compensation administrative law judge at a contested hearing rejected by the workers' compensation administrative law judge or the appeals board pursuant to this section during the most recent two-year period during which the physician served as a qualified medical evaluator. If the workers' compensation administrative law judge or the appeals board rejects the qualified medical evaluator's report on the basis that it fails to meet the minimum standards for those reports established by the administrative director or the appeals board, the workers' compensation administrative law judge or the appeals board, as the case may be, shall make a specific finding to that effect, and shall give notice to the medical evaluator and to the administrative director. Any rejection shall not be counted as one of the five qualifying rejections until the specific finding has become final and time for appeal has expired.

(3) Has completed within the previous 24 months at least 12 hours of continuing education in impairment evaluation or workers' compensation-related medical dispute evaluation approved by the administrative director.

(4) Has not been terminated, suspended, placed on probation, or otherwise disciplined by the administrative director during his or her most recent term as a qualified medical evaluator.

If the evaluator does not meet any one of these criteria, the administrative director may in his or her discretion reappoint or deny reappointment according to regulations adopted by the administrative director. In no event may a physician who does not currently meet the requirements for initial appointment or who has been terminated under subdivision (e) because his or her license

has been revoked or terminated by the licensing authority be reappointed.

(e) The administrative director may, in his or her discretion, suspend or terminate a qualified medical evaluator during his or her term of appointment without a hearing as provided under subdivision (k) or (*l*) whenever either of the following conditions occurs:

(1) The evaluator's license to practice in California has been suspended by the relevant licensing authority so as to preclude practice, or has been revoked or terminated by the licensing authority.

(2) The evaluator has failed to timely pay the fee required by the administrative director pursuant to subdivision (n).

(f) The administrative director shall furnish a physician, upon request, with a written statement of its reasons for termination of, or for denying appointment or reappointment as, a qualified medical evaluator. Upon receipt of a specific response to the statement of reasons, the administrative director shall review his or her decision not to appoint or reappoint the physician or to terminate the physician and shall notify the physician of its final decision within 60 days after receipt of the physician's response.

(g) The administrative director shall establish agreements with qualified medical evaluators to assure the expeditious evaluation of cases assigned to them for comprehensive medical evaluations.

(h) (1) When the injured worker is not represented by an attorney, the medical director appointed pursuant to Section 122, shall assign three-member panels of qualified medical evaluators within five working days after receiving a request for a panel. If a panel is not assigned within 15 working days, the employee shall have the right to obtain a medical evaluation from any qualified medical evaluator of his or her choice. The medical director shall use a random selection method for assigning panels of qualified medical evaluators. The medical director shall select evaluators who are specialists of the type selected by the employee. The medical director shall advise the employee that he or she should consult with his or her treating physician prior to deciding which type of specialist to request.

(2) The administrative director shall promulgate a form that shall notify the employee of the physicians selected for his or her panel. The form shall include, for each physician on the panel, the

physician's name, address, telephone number, specialty, number of years in practice, and a brief description of his or her education and training, and shall advise the employee that he or she is entitled to receive transportation expenses and temporary disability for each day necessary for the examination. The form shall also state in a clear and conspicuous location and type: ''You have the right to consult with an information and assistance officer at no cost to you prior to selecting the doctor to prepare your evaluation, or you may consult with an attorney. If your claim eventually goes to court, the workers' compensation administrative law judge will consider the evaluation prepared by the doctor you select to decide your claim.''

(3) When compiling the list of evaluators from which to select randomly, the medical director shall include all qualified medical evaluators who meet all of the following criteria:

(A) He or she does not have a conflict of interest in the case, as defined by regulations adopted pursuant to subdivision (o).

(B) He or she is certified by the administrative director to evaluate in an appropriate specialty and at locations within the general geographic area of the employee's residence.

(C) He or she has not been suspended or terminated as a qualified medical evaluator for failure to pay the fee required by the administrative director pursuant to subdivision (n) or for any other reason.

(4) When the medical director determines that an employee has requested an evaluation by a type of specialist that is appropriate for the employee's injury, but there are not enough qualified medical evaluators of that type within the general geographic area of the employee's residence to establish a three-member panel, the medical director shall include sufficient qualified medical evaluators from other geographic areas and the employer shall pay all necessary travel costs incurred in the event the employee selects an evaluator from another geographic area.

(i) The medical director appointed pursuant to Section 122, shall continuously review the quality of comprehensive medical evaluations and reports prepared by agreed and qualified medical evaluators and the timeliness with which evaluation reports are prepared and submitted. The review shall include, but not be limited to, a review of a random sample of reports submitted to the division, and a review of all reports alleged to be inaccurate or

incomplete by a party to a case for which the evaluation was prepared. The medical director shall submit to the administrative director an annual report summarizing the results of the continuous review of medical evaluations and reports prepared by agreed and qualified medical evaluators and make recommendations for the improvement of the system of medical evaluations and determinations.

(j) After public hearing pursuant to Section 5307.3, the administrative director shall adopt regulations concerning the following issues:

(1) Standards governing the timeframes within which medical evaluations shall be prepared and submitted by agreed and qualified medical evaluators. Except as provided in this subdivision, the timeframe for initial medical evaluations to be prepared and submitted shall be no more than 30 days after the evaluator has seen the employee or otherwise commenced the medical evaluation procedure. The administrative director shall develop regulations governing the provision of extensions of the 30-day period in cases: (A) where the evaluator has not received test results or consulting physician's evaluations in time to meet the 30-day deadline; and, (B) to extend the 30-day period by not more than 15 days when the failure to meet the 30-day deadline was for good cause. For purposes of this subdivision, ''good cause'' means: (i) medical emergencies of the evaluator or evaluator's family; (ii) death in the evaluator's family; or, (iii) natural disasters or other community catastrophes that interrupt the operation of the evaluator's business. The administrative director shall develop timeframes governing availability of qualified medical evaluators for unrepresented employees under Sections 4061 and 4062. These timeframes shall give the employee the right to the addition of a new evaluator to his or her panel, selected at random, for each evaluator not available to see the employee within a specified period of time, but shall also permit the employee to waive this right for a specified period of time thereafter.

(2) Procedures to be followed by all physicians in evaluating the existence and extent of permanent impairment and limitations resulting from an injury. In order to produce complete, accurate, uniform, and replicable evaluations, the procedures shall require that an evaluation of anatomical loss, functional loss, and the

presence of physical complaints be supported, to the extent feasible, by medical findings based on standardized examinations and testing techniques generally accepted by the medical community.

(3) Procedures governing the determination of any disputed medical issues.

(4) Procedures to be used in determining the compensability of psychiatric injury. The procedures shall be in accordance with Section 3208.3 and shall require that the diagnosis of a mental disorder be expressed using the terminology and criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine.

(5) Guidelines for the range of time normally required to perform the following:

(A) A medical-legal evaluation that has not been defined and valued pursuant to Section 5307.6. The guidelines shall establish minimum times for patient contact in the conduct of the evaluations, and shall be consistent with regulations adopted pursuant to Section 5307.6.

(B) Any treatment procedures that have not been defined and valued pursuant to Section 5307.1.

(C) Any other evaluation procedure requested by the Insurance Commissioner, or deemed appropriate by the administrative director.

(6) Any additional medical or professional standards that a medical evaluator shall meet as a condition of appointment, reappointment, or maintenance in the status of a medical evaluator.

(k) Except as provided in this subdivision, the administrative director may, in his or her discretion, suspend or terminate the privilege of a physician to serve as a qualified medical evaluator if the administrative director, after hearing pursuant to subdivision (*l*), determines, based on substantial evidence, that a qualified medical evaluator:

(1) Has violated any material statutory or administrative duty.

(2) Has failed to follow the medical procedures or qualifications established pursuant to paragraph (2), (3), (4), or (5) of subdivision (j).

(3) Has failed to comply with the timeframe standards established pursuant to subdivision (j).

(4) Has failed to meet the requirements of subdivision (b) or (c).

(5) Has prepared medical-legal evaluations that fail to meet the minimum standards for those reports established by the administrative director or the appeals board.

(6) Has made material misrepresentations or false statements in an application for appointment or reappointment as a qualified medical evaluator.

No hearing shall be required prior to the suspension or termination of a physician's privilege to serve as a qualified medical evaluator when the physician has done either of the following:

(A) Failed to timely pay the fee required pursuant to subdivision (n).

(B) Had his or her license to practice in California suspended by the relevant licensing authority so as to preclude practice, or had the license revoked or terminated by the licensing authority.

(*l*) The administrative director shall cite the qualified medical evaluator for a violation listed in subdivision (k) and shall set a hearing on the alleged violation within 30 days of service of the citation on the qualified medical evaluator. In addition to the authority to terminate or suspend the qualified medical evaluator upon finding a violation listed in subdivision (k), the administrative director may, in his or her discretion, place a qualified medical evaluator on probation subject to appropriate conditions, including ordering continuing education or training. The administrative director shall report to the appropriate licensing board the name of any qualified medical evaluator who is disciplined pursuant to this subdivision.

(m) The administrative director shall terminate from the list of medical evaluators any physician where licensure has been terminated by the relevant licensing board, or who has been convicted of a misdemeanor or felony related to the conduct of his or her medical practice, or of a crime of moral turpitude. The administrative director shall suspend or terminate as a medical evaluator any physician who has been suspended or placed on probation by the relevant licensing board. If a physician is suspended or terminated as a qualified medical evaluator under

this subdivision, a report prepared by the physician that is not complete, signed, and furnished to one or more of the parties prior to the date of conviction or action of the licensing board, whichever is earlier, shall not be admissible in any proceeding before the appeals board nor shall there be any liability for payment for the report and any expense incurred by the physician in connection with the report.

(n) Each qualified medical evaluator shall pay a fee, as determined by the administrative director, for appointment or reappointment. These fees shall be based on a sliding scale as established by the administrative director. All revenues from fees paid under this subdivision shall be deposited into the Workers' Compensation Administration Revolving Fund and are available for expenditure upon appropriation by the Legislature, and shall not be used by any other department or agency or for any purpose other than administration of the programs the Division of Workers' Compensation related to the provision of medical treatment to injured employees.

(o) An evaluator may not request or accept any compensation or other thing of value from any source that does or could create a conflict with his or her duties as an evaluator under this code. The administrative director, after consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt regulations to implement this subdivision.

SEC. 11. Section 139.3 of the Labor Code is amended to read:

139.3. (a) Notwithstanding any other provision of law, to the extent those services are paid pursuant to Division 4 (commencing with Section 3200), it is unlawful for a physician to refer a person for clinical laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, outpatient surgery, or diagnostic imaging goods or services whether for treatment or medical-legal purposes if the physician or his or her immediate family, has a financial interest with the person or in the entity that receives the referral.

(b) For purposes of this section and Section 139.31, the following shall apply:

(1) ''Diagnostic imaging'' includes, but is not limited to, all X-ray, computed axial tomography magnetic resonance imaging,

nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.

(2) ‘‘Immediate family’’ includes the spouse and children of the physician, the parents of the physician, and the spouses of the children of the physician.

(3) ‘‘Physician’’ means a physician as defined in Section 3209.3.

(4) A ‘‘financial interest’’ includes, but is not limited to, any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the physician refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect relationship between a physician and the referral recipient, including, but not limited to, an arrangement whereby a physician has an ownership interest in any entity that leases property to the referral recipient. Any financial interest transferred by a physician to, or otherwise established in, any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the physician.

(5) A ‘‘physician’s office’’ is either of the following:

(A) An office of a physician in solo practice.

(B) An office in which the services or goods are personally provided by the physician or by employees in that office, or personally by independent contractors in that office, in accordance with other provisions of law. Employees and independent contractors shall be licensed or certified when that licensure or certification is required by law.

(6) The ‘‘office of a group practice’’ is an office or offices in which two or more physicians are legally organized as a partnership, professional corporation, or not-for-profit corporation licensed according to subdivision (a) of Section 1204 of the Health and Safety Code for which all of the following are applicable:

(A) Each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel.

(B) Substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group, and except that in the case of multispecialty clinics, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code, physician services are billed in the name of the multispecialty clinic and amounts so received are treated as receipts of the multispecialty clinic.

(C) The overhead expenses of, and the income from, the practice are distributed in accordance with methods previously determined by members of the group.

(7) Outpatient surgery includes both of the following:

(A) Any procedure performed on an outpatient basis in the operating rooms, ambulatory surgery rooms, endoscopy units, cardiac catheterization laboratories, or other sections of a freestanding ambulatory surgery clinic, whether or not licensed under paragraph (1) of subdivision (b) of Section 1204 of the Health and Safety Code.

(B) The ambulatory surgery itself.

(c) (1) It is unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of this section.

(2) It shall be unlawful for a physician to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for a referred evaluation or consultation.

(d) No claim for payment shall be presented by an entity to any individual, third-party payor, or other entity for any goods or services furnished pursuant to a referral prohibited under this section.

(e) A physician who refers to or seeks consultation from an organization in which the physician has a financial interest shall disclose this interest to the patient or if the patient is a minor, to the patient's parents or legal guardian in writing at the time of the referral.

(f) No insurer, self-insurer, or other payor shall pay a charge or lien for any goods or services resulting from a referral in violation of this section.

(g) A violation of subdivision (a) shall be a misdemeanor. The appropriate licensing board shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars ($5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), (e), or (f) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars ($15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California or other appropriate governmental agency.

SEC. 12. Section 139.31 of the Labor Code is amended to read:

139.31. The prohibition of Section 139.3 shall not apply to or restrict any of the following:

(a) A physician may refer a patient for a good or service otherwise prohibited by subdivision (a) of Section 139.3 if the physician's regular practice is where there is no alternative provider of the service within either 25 miles or 40 minutes traveling time, via the shortest route on a paved road. A physician who refers to, or seeks consultation from, an organization in which the physician has a financial interest under this subdivision shall disclose this interest to the patient or the patient's parents or legal guardian in writing at the time of referral.

(b) A physician who has one or more of the following arrangements with another physician, a person, or an entity, is not prohibited from referring a patient to the physician, person, or entity because of the arrangement:

(1) A loan between a physician and the recipient of the referral, if the loan has commercially reasonable terms, bears interest at the prime rate or a higher rate that does not constitute usury, is adequately secured, and the loan terms are not affected by either party's referral of any person or the volume of services provided by either party.

(2) A lease of space or equipment between a physician and the recipient of the referral, if the lease is written, has commercially reasonable terms, has a fixed periodic rent payment, has a term of one year or more, and the lease payments are not affected by either party's referral of any person or the volume of services provided by either party.

(3) A physician's ownership of corporate investment securities, including shares, bonds, or other debt instruments that were purchased on terms that are available to the general public through a licensed securities exchange or NASDAQ, do not base profit distributions or other transfers of value on the physician's referral of persons to the corporation, do not have a separate class or accounting for any persons or for any physicians who may refer persons to the corporation, and are in a corporation that had, at the end of the corporation's most recent fiscal year, total gross assets exceeding one hundred million dollars ($100,000,000).

(4) A personal services arrangement between a physician or an immediate family member of the physician and the recipient of the referral if the arrangement meets all of the following requirements:

(A) It is set out in writing and is signed by the parties.

(B) It specifies all of the services to be provided by the physician or an immediate family member of the physician.

(C) The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.

(D) A written notice disclosing the existence of the personal services arrangement and including information on where a person may go to file a complaint against the licensee or the immediate family member of the licensee, is provided to the following persons at the time any services pursuant to the arrangement are first provided:

(i) An injured worker who is referred by a licensee or an immediate family member of the licensee.

(ii) The injured worker's employer, if self-insured.

(iii) The injured worker's employer's insurer, if insured.

(iv) If the injured worker is known by the licensee or the recipient of the referral to be represented, the injured worker's attorney.

(E) The term of the arrangement is for at least one year.

(F) The compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties, except that if the services provided pursuant to the arrangement include medical services provided under Division 4, compensation paid for the services shall be subject to the official medical fee schedule promulgated pursuant to Section 5307.1 or subject to any contract authorized by Section 5307.11.

(G) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

(c) (1) A physician may refer a person to a health facility as defined in Section 1250 of the Health and Safety Code, to any facility owned or leased by a health facility, or to an outpatient surgical center, if the recipient of the referral does not compensate the physician for the patient referral, and any equipment lease arrangement between the physician and the referral recipient complies with the requirements of paragraph (2) of subdivision (b).

(2) Nothing shall preclude this subdivision from applying to a physician solely because the physician has an ownership or leasehold interest in an entire health facility or an entity that owns or leases an entire health facility.

(3) A physician may refer a person to a health facility for any service classified as an emergency under subdivision (a) or (b) of Section 1317.1 of the Health and Safety Code. For nonemergency outpatient diagnostic imaging services performed with equipment for which, when new, has a commercial retail price of four hundred thousand dollars ($400,000) or more, the referring physician shall obtain a service preauthorization from the insurer, or self-insured employer. Any oral authorization shall be memorialized in writing within five business days.

(d) A physician compensated or employed by a university may refer a person to any facility owned or operated by the university, or for a physician service, to another physician employed by the university, provided that the facility or university does not compensate the referring physician for the patient referral. For nonemergency diagnostic imaging services performed with equipment that, when new, has a commercial retail price of four

hundred thousand dollars ($400,000) or more, the referring physician shall obtain a service preauthorization from the insurer or self-insured employer. An oral authorization shall be memorialized in writing within five business days. In the case of a facility which is totally or partially owned by an entity other than the university, but which is staffed by university physicians, those physicians may not refer patients to the facility if the facility compensates the referring physician for those referrals.

(e) The prohibition of Section 139.3 shall not apply to any service for a specific patient that is performed within, or goods that are supplied by, a physician's office, or the office of a group practice. Further, the provisions of Section 139.3 shall not alter, limit, or expand a physician's ability to deliver, or to direct or supervise the delivery of, in-office goods or services according to the laws, rules, and regulations governing his or her scope of practice. With respect to diagnostic imaging services performed with equipment that, when new, had a commercial retail price of four hundred thousand dollars ($400,000) or more, or for physical therapy services, or for psychometric testing that exceeds the routine screening battery protocols, with a time limit of two to five hours, established by the administrative director, the referring physician obtains a service preauthorization from the insurer or self-insured employer. Any oral authorization shall be memorialized in writing within five business days.

(f) The prohibition of Section 139.3 shall not apply where the physician is in a group practice as defined in Section 139.3 and refers a person for services specified in Section 139.3 to a multispecialty clinic, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code. For diagnostic imaging services performed with equipment that, when new, had a commercial retail price of four hundred thousand dollars ($400,000) or more, or physical therapy services, or psychometric testing that exceeds the routine screening battery protocols, with a time limit of two to five hours, established by the administrative director, performed at the multispecialty facility, the referring physician shall obtain a service preauthorization from the insurer or self-insured employer. Any oral authorization shall be memorialized in writing within five business days.

(g) The requirement for preauthorization in Sections (c), (e), and (f) shall not apply to a patient for whom the physician or group accepts payment on a capitated risk basis.

(h) The prohibition of Section 139.3 shall not apply to any facility when used to provide health care services to an enrollee of a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(i) The prohibition of Section 139.3 shall not apply to an outpatient surgical center, as defined in paragraph (7) of subdivision (b) of Section 139.3, where the referring physician obtains a service preauthorization from the insurer or self-insured employer after disclosure of the financial relationship.

SEC. 13. Section 139.4 of the Labor Code is amended to read:

139.4. (a) The administrative director may review advertising copy to ensure compliance with Section 651 of the Business and Professions Code and may require qualified medical evaluators to maintain a file of all advertising copy for a period of 90 days from the date of its use. Any file so required to be maintained shall be available to the administrative director upon the administrative director's request for review.

(b) No advertising copy shall be used after its use has been disapproved by the administrative director and the qualified medical evaluator has been notified in writing of the disapproval.

(c) A qualified medical evaluator who is found by the administrative director to have violated any provision of this section may be terminated, suspended, or placed on probation.

(d) Proceedings to determine whether a violation of this section has occurred shall be conducted pursuant to Chapter 4 (commencing with Section 11370) of Part 1 of Division 3 of Title 2 of the Government Code.

(e) The administrative director shall adopt regulations governing advertising by physicians with respect to industrial injuries or illnesses.

(f) Subdivision (a) shall not be construed to alter the application of Section 651 of the Business and Professions Code.

SEC. 14. Section 139.45 of the Labor Code is amended to read:

139.45. (a) In promulgating regulations pursuant to Sections 139.4 and 139.43, the administrative director shall take particular

care to preclude any advertisements with respect to industrial injuries or illnesses that are false or mislead the public with respect to workers' compensation. In promulgating rules with respect to advertising, the State Bar and physician licensing boards shall also take particular care to achieve the same goal.

(b) For purposes of subdivision (a), false or misleading advertisements shall include advertisements that do any of the following:

(1) Contain an untrue statement.

(2) Contain any matter, or present or arrange any matter in a manner or format that is false, deceptive, or that tends to confuse, deceive, or mislead.

(3) Omit any fact necessary to make the statement made, in the light of the circumstances under which the statement is made, not misleading.

(4) Are transmitted in any manner that involves coercion, duress, compulsion, intimidation, threats, or vexatious or harassing conduct.

(5) Entice a person to respond by the offering of any consideration, including a good or service but excluding free medical evaluations or treatment, that would be provided either at no charge or for less than market value. No free medical evaluation or treatment shall be offered for the purpose of defrauding any entity.

SEC. 14.3. Section 3201.7 of the Labor Code, as added by Chapter 6 of the Statutes of 2002, is repealed.

SEC. 14.5. Section 3201.7 of the Labor Code, as added by Chapter 866 of the Statutes of 2002, is repealed.

SEC. 14.7. Section 3201.7 is added to the Labor Code, to read:

3201.7. (a) Except as provided in subdivision (b), the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any labor-management agreement that meets all of the following requirements:

(1) The labor-management agreement has been negotiated separate and apart from any collective bargaining agreement covering affected employees.

(2) The labor-management agreement is restricted to the establishment of the terms and conditions necessary to implement this section.

(3) The labor-management agreement has been negotiated in accordance with the authorization of the administrative director pursuant to subdivision (d), between an employer or groups of employers and a union that is the recognized or certified exclusive bargaining representative that establishes any of the following:

(A) An alternative dispute resolution system governing disputes between employees and employers or their insurers that supplements or replaces all or part of those dispute resolution processes contained in this division, including, but not limited to, mediation and arbitration. Any system of arbitration shall provide that the decision of the arbiter or board of arbitration is subject to review by the appeals board in the same manner as provided for reconsideration of a final order, decision, or award made and filed by a workers' compensation administrative law judge pursuant to the procedures set forth in Article 1 (commencing with Section 5900) of Chapter 7 of Part 4 of Division 4, and the court of appeals pursuant to the procedures set forth in Article 2 (commencing with Section 5950) of Chapter 7 of Part 4 of Division 4, governing orders, decisions, or awards of the appeals board. The findings of fact, award, order, or decision of the arbitrator shall have the same force and effect as an award, order, or decision of a workers' compensation administrative law judge. Any provision for arbitration established pursuant to this section shall not be subject to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.

(B) The use of an agreed list of providers of medical treatment that may be the exclusive source of all medical treatment provided under this division.

(C) The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the exclusive source of qualified medical evaluators and agreed medical evaluators under this division.

(D) Joint labor management safety committees.

(E) A light-duty, modified job, or return-to-work program.

(F) A vocational rehabilitation or retraining program utilizing an agreed list of providers of rehabilitation services that may be the exclusive source of providers of rehabilitation services under this division.

(b) Nothing in this section shall allow a labor-management agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary

disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this division; nor shall any agreement authorized by this section deny to any employee the right to representation by counsel at all stages during the alternative dispute resolution process. The portion of any agreement that violates this subdivision shall be declared null and void.

(c) Subdivision (a) shall apply only to the following:

(1) An employer developing or projecting an annual workers' compensation insurance premium, in California, of fifty thousand dollars ($50,000) or more, and employing at least 50 employees, or any employer that paid an annual workers' compensation insurance premium, in California, of fifty thousand dollars ($50,000), and employing at least 50 employees in at least one of the previous three years.

(2) Groups of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the Insurance Code, and established pursuant to a joint labor management safety committee or committees, that develops or projects annual workers' compensation insurance premiums of five hundred thousand dollars ($500,000) or more.

(3) Employers or groups of employers, including cities and counties, that are self-insured in compliance with Section 3700 that would have projected annual workers' compensation costs that meet the requirements of, and that meet the other requirements of, paragraph (1) in the case of employers, or paragraph (2) in the case of groups of employers.

(d) Any recognized or certified exclusive bargaining representative in an industry not covered by Section 3201.5, may file a petition with the administrative director seeking permission to negotiate with an employer or group of employers to enter into a labor-management agreement pursuant to this section. The petition shall specify the bargaining unit or units to be included, the names of the employers or groups of employers, and shall be accompanied by proof of the labor union's status as the exclusive bargaining representative. The current collective bargaining agreement or agreements shall be attached to the petition. The petition shall be in the form designated by the administrative director. Upon receipt of the petition, the administrative director shall promptly verify the petitioner's status as the exclusive

bargaining representative. If the petition satisfies the requirements set forth in this subdivision, the administrative director shall issue a letter advising each employer and labor representative of their eligibility to enter into negotiations, for a period not to exceed one year, for the purpose of reaching agreement on a labor-management agreement pursuant to this section. The parties may jointly request, and shall be granted, by the administrative director, an additional one-year period to negotiate an agreement.

(e) No employer may establish or continue a program established under this section until it has provided the administrative director with all of the following:

(1) Upon its original application and whenever it is renegotiated thereafter, a copy of the labor-management agreement and the approximate number of employees who will be covered thereby.

(2) Upon its original application and annually thereafter, a statement signed under penalty of perjury, that no action has been taken by any administrative agency or court of the United States to invalidate the labor-management agreement.

(3) The name, address, and telephone number of the contact person of the employer.

(4) Any other information that the administrative director deems necessary to further the purposes of this section.

(f) No collective bargaining representative may establish or continue to participate in a program established under this section unless all of the following requirements are met:

(1) Upon its original application and annually thereafter, it has provided to the administrative director a copy of its most recent LM-2 or LM-3 filing with the United States Department of Labor, where such filing is required by law, along with a statement, signed under penalty of perjury, that the document is a true and correct copy.

(2) It has provided to the administrative director the name, address, and telephone number of the contact person or persons of the collective bargaining representative or representatives.

(g) Commencing July 1, 2005, and annually thereafter, the Division of Workers' Compensation shall report to the Director of Industrial Relations the number of labor-management agreements received and the number of employees covered by these agreements.

(h) By June 30, 2006, and annually thereafter, the administrative director shall prepare and notify Members of the Legislature that a report authorized by this section is available upon request. The report based upon aggregate data shall include the following:

(1) Person hours and payroll covered by agreements filed.

(2) The number of claims filed.

(3) The average cost per claim shall be reported by cost components whenever practicable.

(4) The number of litigated claims, including the number of claims submitted to mediation, the appeals board, or the court of appeal.

(5) The number of contested claims resolved prior to arbitration.

(6) The projected incurred costs and actual costs of claims.

(7) Safety history.

(8) The number of workers participating in vocational rehabilitation.

(9) The number of workers participating in light-duty programs.

(10) Overall worker satisfaction.

The division shall have the authority to require employers and groups of employers participating in labor-management agreements pursuant to this section to provide the data listed above.

(i) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation shall create derivative works pursuant to subdivisions (f) and (g) based on the labor-management agreements and data. Those derivative works shall not be confidential, but shall be public. On a monthly basis, the administrative director shall make available an updated list of employers and unions entering into labor-management agreements authorized by this section.

SEC. 15. Section 3823 is added to the Labor Code, to read:

3823. (a) The administrative director shall, in coordination with the Bureau of Fraudulent Claims of the Department of Insurance, the Medi-Cal Fraud Task Force, and the Bureau of Medi-Cal Fraud and Elder Abuse of the Department of Justice,

adopt protocols, to the extent that these protocols are applicable to achieve the purpose of subdivision (b), similar to those adopted by the Department of Insurance concerning medical billing and provider fraud.

(b) Any insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that believes that a fraudulent claim has been made by any person or entity providing medical care, as described in Section 4600, shall report the apparent fraudulent claim in the manner prescribed by subdivision (a).

SEC. 16. Section 4061 of the Labor Code is amended to read:

4061. (a) Together with the last payment of temporary disability indemnity, the employer shall, in a form prescribed by the administrative director pursuant to Section 138.4, provide the employee one of the following:

(1) Notice either that no permanent disability indemnity will be paid because the employer alleges the employee has no permanent impairment or limitations resulting from the injury or notice of the amount of permanent disability indemnity determined by the employer to be payable. The notice shall include information concerning how the employee may obtain a formal medical evaluation pursuant to subdivision (c) if he or she disagrees with the position taken by the employer. The notice shall be accompanied by the form prescribed by the administrative director for requesting assignment of a panel of qualified medical evaluators, unless the employee is represented by an attorney. If the employer determines permanent disability indemnity is payable, the employer shall advise the employee of the amount determined payable and the basis on which the determination was made and whether there is need for continuing medical care.

(2) Notice that permanent disability indemnity may be or is payable, but that the amount cannot be determined because the employee's medical condition is not yet permanent and stationary. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time the necessary evaluation will be performed to determine the existence and extent of permanent impairment and limitations for the purpose of rating permanent disability and to determine the need for continuing medical care, or at which time the employer will advise the employee of the amount of permanent

disability indemnity the employer has determined to be payable. If an employee is provided notice pursuant to this paragraph and the employer later takes the position that the employee has no permanent impairment or limitations resulting from the injury, or later determines permanent disability indemnity is payable, the employer shall in either event, within 14 days of the determination to take either position, provide the employee with the notice specified in paragraph (1).

(b) Each notice required by subdivision (a) shall describe the administrative procedures available to the injured employee and advise the employee of his or her right to consult an information and assistance officer or an attorney. It shall contain the following language:

''Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.''

(c) If the parties do not agree to a permanent disability rating based on the treating physician's evaluation or the assessment of need for continuing medical care, and the employee is represented by an attorney, the employer shall seek agreement with the employee on a physician to prepare a comprehensive medical evaluation of the employee's permanent impairment and limitations and any need for continuing medical care resulting from the injury. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed to by the parties, the parties may not later select an agreed medical evaluator. Evaluations of an employee's permanent impairment and limitations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, either party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense.

(d) If the parties do not agree to a permanent disability rating based on the treating physician's evaluation, and if the employee

is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare an additional medical evaluation. The employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a medical evaluation of the employee's permanent impairment and limitations and any need for continuing medical care resulting from the injury.

For injuries occurring on or after January 1, 2003, except as provided in subdivision (b) of Section 4064, the report of the qualified medical evaluator and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or the employer on the issues subject to this section.

(e) If an employee obtains a qualified medical evaluator from a panel pursuant to subdivision (d) or pursuant to subdivision (b) of Section 4062, and thereafter becomes represented by an attorney and obtains an additional qualified medical evaluator, the employer shall have a corresponding right to secure an additional qualified medical evaluator.

(f) The represented employee shall be responsible for making an appointment with an agreed medical evaluator.

(g) The unrepresented employee shall be responsible for making an appointment with a qualified medical evaluator selected from a panel of three qualified medical evaluators. The evaluator shall give the employee, at the appointment, a brief opportunity to ask questions concerning the evaluation process and the evaluator's background. The unrepresented employee shall then participate in the evaluation as requested by the evaluator unless the employee has good cause to discontinue the evaluation. For purposes of this subdivision, ''good cause'' shall include evidence that the evaluator is biased against the employee because of his or her race, sex, national origin, religion, or sexual preference or evidence that the evaluator has requested the employee to submit to an unnecessary medical examination or procedure. If the unrepresented employee declines to proceed with the evaluation, he or she shall have the right to a new panel of three qualified medical evaluators from which to select one to prepare a comprehensive medical evaluation. If the appeals board

subsequently determines that the employee did not have good cause to not proceed with the evaluation, the cost of the evaluation shall be deducted from any award the employee obtains.

(h) Upon selection or assignment pursuant to subdivision (c) or (d), the medical evaluator shall perform a comprehensive medical evaluation according to the procedures promulgated by the administrative director under paragraphs (2) and (3) of subdivision (j) of Section 139.2 and summarize the medical findings on a form prescribed by the administrative director. The comprehensive medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a comprehensive medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

(i) Except as provided in Section 139.3, the medical evaluator may obtain consultations from other physicians who have treated the employee for the injury whose expertise is necessary to provide a complete and accurate evaluation.

(j) The qualified medical evaluator who has evaluated an unrepresented employee shall serve the comprehensive medical evaluation and the summary form on the employee, employer, and the administrative director. The unrepresented employee or the employer may submit the treating physician's evaluation for the calculation of a permanent disability rating. Within 20 days of receipt of the comprehensive medical evaluation, the administrative director shall calculate the permanent disability rating according to Section 4660 and serve the rating on the employee and employer.

(k) Any comprehensive medical evaluation concerning an unrepresented employee which indicates that part or all of an employee's permanent impairment or limitations may be subject to apportionment pursuant to Sections 4663 or 4750 shall first be submitted by the administrative director to a workers' compensation judge who may refer the report back to the qualified medical evaluator for correction or clarification if the judge determines the proposed apportionment is inconsistent with the law.

(*l*) Within 30 days of receipt of the rating, if the employee is unrepresented, the employee or employer may request that the administrative director reconsider the recommended rating or obtain additional information from the treating physician or medical evaluator to address issues not addressed or not completely addressed in the original comprehensive medical evaluation or not prepared in accord with the procedures promulgated under paragraph (2) or (3) of subdivision (j) of Section 139.2. This request shall be in writing, shall specify the reasons the rating should be reconsidered, and shall be served on the other party. If the administrative director finds the comprehensive medical evaluation is not complete or not in compliance with the required procedures, the administrative director shall return the report to the treating physician or qualified medical evaluator for appropriate action as the administrative director instructs. Upon receipt of the treating physician's or qualified medical evaluator's final comprehensive medical evaluation and summary form, the administrative director shall recalculate the permanent disability rating according to Section 4660 and serve the rating, the comprehensive medical evaluation, and the summary form on the employee and employer.

(m) If a comprehensive medical evaluation from the treating physician or an agreed medical evaluator or a qualified medical evaluator selected from a three-member panel resolves any issue so as to require an employer to provide compensation, the employer shall commence the payment of compensation or promptly commence proceedings before the appeals board to resolve the dispute. If the employee and employer agree to a stipulated findings and award as provided under Section 5702 or to compromise and release the claim under Chapter 2 (commencing with Section 5000) of Part 3, or if the employee wishes to commute the award under Chapter 3 (commencing with Section 5100) of Part 3, the appeals board shall first determine whether the agreement or commutation is in the best interests of the employee and whether the proper procedures have been followed in determining the permanent disability rating. The administrative director shall promulgate a form to notify the employee, at the time of service of any rating under this section, of the options specified in this subdivision, the potential

advantages and disadvantages of each option, and the procedure for disputing the rating.

(n) No issue relating to the existence or extent of permanent impairment and limitations or the need for continuing medical care resulting from the injury may be the subject of a declaration of readiness to proceed unless there has first been a medical evaluation by a treating physician or an agreed or qualified medical evaluator. With the exception of an evaluation or evaluations prepared by the treating physician or physicians, no evaluation of permanent impairment and limitations or need for continuing medical care resulting from the injury shall be obtained prior to service of the comprehensive medical evaluation on the employee and employer if the employee is unrepresented, or prior to the attempt to select an agreed medical evaluator if the employee is represented. Evaluations obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury and comprehensive medical evaluations prepared by a qualified medical evaluator selected by an unrepresented employee from a three-member panel shall be admissible.

SEC. 16.5. Section 4062 of the Labor Code is repealed.

SEC. 17. Section 4062 is added to the Labor Code, to read:

4062. (a) If either the employee or employer objects to a medical determination made by the treating physician concerning the permanent and stationary status of the employee's medical condition, the employee's preclusion or likely preclusion to engage in his or her usual occupation, the extent and scope of medical treatment, the existence of new and further disability, or any other medical issues not covered by Section 4060 or 4061, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. Employer objections to the treating physician's recommendation for spinal surgery shall be subject to subdivision (b), and after denial of the physician's recommendation, in accordance with Section 4610. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, the

parties shall seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed upon by the parties, the parties may not later select an agreed medical evaluator. Evaluations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, the objecting party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. The nonobjecting party may continue to rely on the treating physician's report or may select a qualified medical evaluator to conduct an additional evaluation.

(b) The employer may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation. If no agreement is reached within 10 days, or if the employee is not represented by an attorney, an orthopedic surgeon or neurosurgeon shall be randomly selected by the administrative director to prepare a second opinion report resolving the disputed surgical recommendation. Examinations shall be scheduled on an expedited basis. The second opinion report shall be served on the parties within 45 days of receipt of the treating physician's report. If the second opinion report recommends surgery, the employer shall authorize the surgery. If the second opinion report does not recommend surgery, the employer shall file a declaration of readiness to proceed. The employer shall not be liable for medical treatment costs for the disputed surgical procedure, whether through a lien filed with the appeals board or as a self-procured medical expense, or for periods of temporary disability resulting from the surgery, if the disputed surgical procedure is performed prior to the completion of the second opinion process required by this subdivision.

(c) The second opinion physician shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:

(1) The employer, his or her workers' compensation insurer, third-party claims administrator, or other entity contracted to provide utilization review services pursuant to Section 4610.

(2) Any officer, director, or employee of the employer's health care provider, workers' compensation insurer, or third-party claims administrator.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer's health care provider, workers' compensation insurer, or third-party claims administrator, would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee or his or her treating physician whose treatment is under review, or the alternative therapy, if any, recommended by the employer or other entity.

(6) The employee or the employee's immediate family.

(d) If the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare the comprehensive medical evaluation. Except in cases where the treating physician's recommendation that spinal surgery be performed pursuant to subdivision (b), the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a comprehensive medical evaluation. For injuries occurring on or after January 1, 2003, except as provided in subdivision (b) of Section 4064, the evaluation of the qualified medical evaluator selected from a panel of three and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or employer on issues subject to this section in a case involving an unrepresented employee.

(e) Upon completing a determination of the disputed medical issue, the physician selected under subdivision (a) or (d) to perform the medical evaluation shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

(f) No disputed medical issue specified in subdivision (a) may be the subject of a declaration of readiness to proceed unless there has first been an evaluation by the treating physician or an agreed or qualified medical evaluator.

(g) With the exception of a report or reports prepared by the treating physician or physicians, no report determining disputed medical issues set forth in subdivision (a) shall be obtained prior to the expiration of the period to reach agreement on the selection of an agreed medical evaluator under subdivision (a). Reports obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury shall be admissible.

(h) This section shall remain in effect only until January 1, 2007, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2007, deletes or extends that date.

SEC. 18. Section 4062.01 is added to the Labor Code, to read:

4062.01. (a) If either the employee or employer objects to a medical determination made by the treating physician concerning the permanent and stationary status of the employee's medical condition, the employee's preclusion or likely preclusion to engage in his or her usual occupation, the extent and scope of medical treatment, the existence of new and further disability, or any other medical issues not covered by Section 4060 or 4061, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee

is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed upon by the parties, the parties may not later select an agreed medical evaluator. Evaluations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, the objecting party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. The nonobjecting party may continue to rely on the treating physician's report or may select a qualified medical evaluator to conduct an additional evaluation.

(b) If the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare the comprehensive medical evaluation. The employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a comprehensive medical evaluation. The evaluation of the qualified medical evaluator selected from a panel of three and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or employer on issues subject to this section in a case involving an unrepresented employee.

(c) Upon completing a determination of the disputed medical issue, the physician selected under subdivision (a) or (b) to perform the medical evaluation shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the

employee's initial appointment with the medical evaluator. If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

(d) No disputed medical issue specified in subdivision (a) may be the subject of a declaration of readiness to proceed unless there has first been an evaluation by the treating physician or an agreed or qualified medical evaluator.

(e) With the exception of a report or reports prepared by the treating physician or physicians, no report determining disputed medical issues set forth in subdivision (a) shall be obtained prior to the expiration of the period to reach agreement on the selection of an agreed medical evaluator under subdivision (a). Reports obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury shall be admissible.

(f) This section shall become operative on January 1, 2007.

SEC. 19. Section 4062.5 of the Labor Code is amended to read:

4062.5. If a qualified medical evaluator selected by an unrepresented employee from a three-member panel fails to complete the formal medical evaluation within the timeframes established by the administrative director pursuant to paragraph (1) of subdivision (j) of Section 139.2, the employee shall have the right to a new panel of three qualified medical evaluators from which to select one to prepare a formal medical evaluation. Neither the employee nor the employer shall have any liability for payment for the formal medical evaluation which was not completed within the required timeframes unless the employee, on a form prescribed by the administrative director, waives his or her right to a new evaluation and elects to accept the original evaluation even though it was not completed within the required timeframes.

SEC. 20. Section 4062.9 of the Labor Code is amended to read:

4062.9. (a) In cases where an additional comprehensive medical evaluation is obtained under Section 4061 or 4062, if the employee has been treated by his or her personal physician, or by

his or her personal chiropractor, as defined in Section 4601, who was predesignated prior to the date of injury as provided under Section 4600, the findings of the personal physician or personal chiropractor are presumed to be correct. This presumption is rebuttable and may be controverted by a preponderance of medical opinion indicating a different level of disability. However, the presumption shall not apply where both parties select qualified medical examiners.

(b) In all cases other than those specified in subdivision (a), regardless of the date of injury, no presumption shall apply to the opinion of any physician on the issue of extent and scope of medical treatment, either prior or subsequent to the issuance of an award.

(c) The administrative director shall develop, not later than January 1, 2004, and periodically revise as necessary thereafter, educational materials to be used to provide treating physicians and chiropractors with information and training in basic concepts of workers' compensation, the role of the treating physician, the conduct of permanent and stationary evaluations, and report writing.

(d) The amendment made to this section by SB 228 of the 2003–04 Regular Session shall not constitute good cause to reopen or rescind, alter, or amend any order, decision, or award of the appeals board.

SEC. 22. Section 4068 of the Labor Code is amended to read:

4068. (a) Upon determining that a treating physician's report contains opinions that are the result of conjecture, are not supported by adequate evidence, or that indicate bias, the appeals board shall so notify the administrative director in writing in a manner he or she has specified.

(b) If the administrative director believes that any treating physician's reports show a pattern of unsupported opinions, he or she shall notify in writing the physician's applicable licensing body of his or her findings.

SEC. 23. Section 4600.1 of the Labor Code is repealed.

SEC. 24. Section 4600.1 is added to the Labor Code, to read:

4600.1. (a) Subject to subdivision (b), any person or entity that dispenses medicines and medical supplies, as required by Section 4600, shall dispense the generic drug equivalent.

(b) A person or entity shall not be required to dispense a generic drug equivalent under either of the following circumstances:

(1) When a generic drug equivalent is unavailable.

(2) When the prescribing physician specifically provides in writing that a nongeneric drug must be dispensed.

(c) For purposes of this section, ‘‘dispense’’ has the same meaning as the definition contained in Section 4024 of the Business and Professions Code.

(d) Nothing in this section shall be construed to preclude a prescribing physician, who is also the dispensing physician, from dispensing a generic drug equivalent.

SEC. 25. Section 4603.2 of the Labor Code is amended to read:

4603.2. (a) Upon selecting a physician pursuant to Section 4600, the employee or physician shall forthwith notify the employer of the name and address of the physician. The physician shall submit a report to the employer within five working days from the date of the initial examination and shall submit periodic reports at intervals that may be prescribed by rules and regulations adopted by the administrative director.

(b) (1) Except as provided in subdivision (d) of Section 4603.4, payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made by the employer within 45 working days after receipt of each separate, itemized billing, together with any required reports and any written authorization for services that may have been received by the physician. If the billing or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in writing, that the billing is contested, denied, or considered incomplete, within 30 working days after receipt of the billing by the employer. A notice that a billing is incomplete shall state all additional information required to make a decision. Any properly documented amount not paid within the 45-working-day period shall be increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill, unless the employer does both of the following:

(A) Pays the uncontested amount within the 45-working-day period.

(B) Advises, in the manner prescribed by the administrative director, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees. In the case of a bill which includes charges from a hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been made for an audit of the bill shall satisfy the requirements of this paragraph.

If an employer contests all or part of a billing, any amount determined payable by the appeals board shall carry interest from the date the amount was due until it is paid. If any contested amount is determined payable by the appeals board, the defendant shall be ordered to reimburse the provider for any filing fees paid pursuant to Section 4903.05.

An employer's liability to a physician or another provider under this section for delayed payments shall not affect its liability to an employee under Section 5814 or any other provision of this division.

(2) Notwithstanding paragraph (1), if the employer is a governmental entity, payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made within 60 working days after receipt of each separate, itemized billing, together with any required reports and any written authorization for services that may have been received by the physician.

(c) Any interest or increase in compensation paid by an insurer pursuant to this section shall be treated in the same manner as an increase in compensation under subdivision (d) of Section 4650 for the purposes of any classification of risks and premium rates, and any system of merit rating approved or issued pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Part 3 of Division 2 of the Insurance Code.

(d) (1) Whenever an employer or insurer employs an individual or contracts with an entity to conduct a review of a billing submitted by a physician or medical provider, the employer or insurer shall make available to that individual or entity all documentation submitted together with that billing by the physician or medical provider. When an individual or entity conducting a bill review determines that additional information or documentation is necessary to review the billing, the individual or

entity shall contact the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the physician or medical provider pursuant to subdivision (b).

(2) An individual or entity reviewing a bill submitted by a physician or medical provider shall not alter the procedure codes billed or recommend reduction of the amount of the bill unless the documentation submitted by the physician or medical provider with the bill has been reviewed by that individual or entity. If the reviewer does not recommend payment as billed by the physician or medical provider, the explanation of review shall provide the physician or medical provider with a specific explanation as to why the reviewer altered the procedure code or amount billed and the specific deficiency in the billing or documentation that caused the reviewer to conclude that the altered procedure code or amount recommended for payment more accurately represents the service performed.

(3) The appeals board shall have jurisdiction over disputes arising out of this subdivision pursuant to Section 5304.

SEC. 26. Section 4603.4 of the Labor Code is amended to read:

4603.4. (a) The administrative director shall adopt rules and regulations to do all of the following:

(1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms.

(2) Require acceptance by employers of electronic claims for payment of medical services.

(3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.

(b) To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996.

(c) The rules and regulations requiring employers to accept electronic claims for payment of medical services shall be adopted on or before January 1, 2005, and shall require all employers to accept electronic claims for payment of medical services on or before July 1, 2006.

(d) Payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made by the employer within 15 working

days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule adopted pursuant to Section 5307.1. If the billing is contested, denied, or incomplete, payment shall be made in accordance with Section 4603.2.

SEC. 27. Section 4604.5 is added to the Labor Code, to read:

4604.5. (a) Upon adoption by the administrative director of a medical treatment utilization schedule pursuant to Section 5307.27, the recommended guidelines set forth in the schedule shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury.

(b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices as generally accepted by the health care community, and shall apply the current standards of care, including, but not limited to, appropriate and inappropriate diagnostic techniques, treatment modalities, adjustive modalities, length of treatment, and appropriate specialty referrals. These guidelines shall be educational and designed to assist providers by offering an analytical framework for the evaluation and treatment of the more common problems of injured workers, and shall assure appropriate and necessary care for all injured workers diagnosed with industrial conditions.

(c) Three months after the publication date of the updated American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines, and continuing until the effective date of a medical treatment utilization schedule, pursuant to Section 5307.27, the recommended guidelines set forth in the American College of Occupational and Environmental Medical Practice Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury.

(d) Notwithstanding the medical treatment utilization schedule or the guidelines set forth in the American College of Occupational

and Environmental Medical Practice Guidelines, for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic and 24 physical therapy visits per industrial injury.

(e) The presumption afforded to the treating physician in Section 4062.9 shall not be applicable to cases arising under this section.

(f) This section shall not apply when an insurance carrier authorizes, in writing, additional visits to a health care practitioner for physical medicine services.

(g) For all injuries not covered by the American College of Occupational and Environmental Medicine Occupational Medicine Practice Guidelines or official utilization schedule after adoption pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the medical community.

SEC. 28. Section 4610 is added to the Labor Code, to read:

4610. (a) For purposes of this section, ''utilization review'' means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines. These policies and procedures, and a description of the utilization process, shall be filed with the

administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the

specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements must be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be

communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4062. If a request to perform spinal surgery is denied, disputes shall be resolved in accordance with subdivision (b) of Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4062, except in cases involving recommendations for the performance of spinal surgery, which shall be governed by the provisions of subdivision (b) of Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

SEC. 29. Section 4628 of the Labor Code is amended to read:

4628. (a) Except as provided in subdivision (c), no person, other than the physician who signs the medical-legal report, except a nurse performing those functions routinely performed by a nurse, such as taking blood pressure, shall examine the injured employee or participate in the nonclerical preparation of the report, including all of the following:

(1) Taking a complete history.

(2) Reviewing and summarizing prior medical records.

(3) Composing and drafting the conclusions of the report.

(b) The report shall disclose the date when and location where the evaluation was performed; that the physician or physicians signing the report actually performed the evaluation; whether the evaluation performed and the time spent performing the evaluation was in compliance with the guidelines established by the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 and shall disclose the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than its clerical preparation. If the report discloses that the evaluation performed or the time spent performing the evaluation was not in compliance with the guidelines established by the administrative director, the report shall explain, in detail, any variance and the reason or reasons therefor.

(c) If the initial outline of a patient's history or excerpting of prior medical records is not done by the physician, the physician shall review the excerpts and the entire outline and shall make additional inquiries and examinations as are necessary and appropriate to identify and determine the relevant medical issues.

(d) No amount may be charged in excess of the direct charges for the physician's professional services and the reasonable costs of laboratory examinations, diagnostic studies, and other medical tests, and reasonable costs of clerical expense necessary to producing the report. Direct charges for the physician's professional services shall include reasonable overhead expense.

(e) Failure to comply with the requirements of this section shall make the report inadmissible as evidence and shall eliminate any liability for payment of any medical-legal expense incurred in connection with the report.

(f) Knowing failure to comply with the requirements of this section shall subject the physician to a civil penalty of up to one thousand dollars ($1,000) for each violation to be assessed by a workers' compensation judge or the appeals board. All civil penalties collected under this section shall be deposited in the Workers' Compensation Administration Revolving Fund.

(g) A physician who is assessed a civil penalty under this section may be terminated, suspended, or placed on probation as

a qualified medical evaluator pursuant to subdivisions (k) and (*l*) of Section 139.2.

(h) Knowing failure to comply with the requirements of this section shall subject the physician to contempt pursuant to the judicial powers vested in the appeals board.

(i) Any person billing for medical-legal evaluations, diagnostic procedures, or diagnostic services performed by persons other than those employed by the reporting physician or physicians, or a medical corporation owned by the reporting physician or physicians shall specify the amount paid or to be paid to those persons for the evaluations, procedures, or services. This subdivision shall not apply to any procedure or service defined or valued pursuant to Section 5307.1.

(j) The report shall contain a declaration by the physician signing the report, under penalty of perjury, stating:

''I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.''

The foregoing declaration shall be dated and signed by the reporting physician and shall indicate the county wherein it was signed.

(k) The physician shall provide a curriculum vitae upon request by a party and include a statement concerning the percent of the physician's total practice time that is annually devoted to medical treatment.

SEC. 33. Section 4903.05 is added to the Labor Code, to read:

4903.05. (a) A filing fee of one hundred dollars ($100) shall be charged for each initial lien filed by providers pursuant to subdivision (b) of Section 4903.

(b) No filing fee shall be required for liens filed by the Veterans Administration, the Medi-Cal program, or public hospitals.

(c) The filing fee shall be collected by the court administrator. All fees shall be deposited in the Workers' Compensation Administration Revolving Fund. Any fees collected from providers that have not been redistributed to providers pursuant to paragraph (2) of subdivision (b) of Section 4603.2, shall be used

to offset the amount of fees assessed on employers under Section 62.5.

(d) The court administrator shall adopt reasonable rules and regulations governing the procedures for the collection of the filing fee.

SEC. 34. Section 5307.1 of the Labor Code is repealed.

SEC. 35. Section 5307.1 is added to the Labor Code, to read:

5307.1. (a) The administrative director, after public hearings, shall adopt and revise periodically an official medical fee schedule that shall establish reasonable maximum fees paid for medical services other than physician services, drugs and pharmacy services, health care facility fees, home health care, and all other treatment, care, services, and goods described in Section 4600 and provided pursuant to this section. Except for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, except for the components listed in subdivisions (k) and (*l*), maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (e), except that for pharmacy services and drugs that are not otherwise covered by a Medicare fee schedule payment for facility services, the maximum reasonable fees shall be 100 percent of fees prescribed in the relevant Medi-Cal payment system. Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed 120 percent of estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (e). Pharmacy services and drugs shall be subject to the requirements of this section, whether furnished through a pharmacy or dispensed directly by the

practitioner pursuant to subdivision (b) of Section 4024 of the Business and Professions Code.

(b) In order to comply with the standards specified in subdivision (f), the administrative director may adopt different conversion factors, diagnostic related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.

(c) Notwithstanding subdivisions (a) and (d), the maximum facility fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, may not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department.

(d) If the administrative director determines that a medical treatment, facility use, product, or service is not covered by a Medicare payment system, the administrative director shall establish maximum fees for that item, provided that the maximum fee paid shall not exceed 120 percent of the fees paid by Medicare for services that require comparable resources. If the administrative director determines that a pharmacy service or drug is not covered by a Medi-Cal payment system, the administrative director shall establish maximum fees for that item, provided, however, that the maximum fee paid shall not exceed 100 percent of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

(e) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, or, with regard to pharmacy services and drugs, for a pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003.

(f) Within the limits provided by this section, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.

(g) (1) (A) Notwithstanding any other provision of law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems

no later than 60 days after the effective date of those changes, provided that both of the following conditions are met:

(i) The annual inflation adjustment for facility fees for inpatient hospital services provided by acute care hospitals and for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year.

(ii) The annual update in the operating standardized amount and capital standard rate for inpatient hospital services provided by hospitals excluded from the Medicare prospective payment system for acute care hospitals and the conversion factor for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for excluded hospitals for the 12 months beginning October 1 of the preceding calendar year.

(B) The update factors contained in clauses (i) and (ii) of subparagraph (A) shall be applied beginning with the first update in the Medicare fee schedule payment amounts after December 31, 2003.

(2) The administrative director shall determine the effective date of the changes, and shall issue an order, exempt from Sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11370) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date. All orders issued pursuant to this paragraph shall be published on the Internet Web site of the division of Workers' Compensation.

(3) For the purposes of this subdivision, the following definitions apply:

(A) ''Medicare Economic Index'' means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of a providing physician and other services paid under the resource-based relative value scale.

(B) ''Hospital market basket'' means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient hospital services provided by acute care hospitals that are included in the Medicare prospective payment system.

(C) ''Hospital market basket for excluded hospitals'' means the input price index used by the federal Centers for Medicare and

Medicaid Services to measure changes in the costs of providing inpatient services by hospitals that are excluded from the Medicare prospective payment system.

(h) Nothing in this section shall prohibit an employer or insurer from contracting with a medical provider for reimbursement rates different from those prescribed in the official medical fee schedule.

(i) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as that term is defined by Section 4620.

(j) The following Medicare payment system components may not become part of the official medical fee schedule until January 1, 2005:

(1) Inpatient skilled nursing facility care.

(2) Home health agency services.

(3) Inpatient services furnished by hospitals that are exempt from the prospective payment system for general acute care hospitals.

(4) Outpatient renal dialysis services.

(k) Notwithstanding subdivision (a), for the calendar years 2004 and 2005, the existing official medical fee schedule rates for physician services shall remain in effect, but these rates shall be reduced by 5 percent. The administrative director may reduce fees of individual procedures by different amounts, but in no event shall the administrative director reduce the fee for a procedure that is currently reimbursed at a rate at or below the Medicare rate for the same procedure.

(*l*) Notwithstanding subdivision (a), the administrative director, commencing January 1, 2006, shall have the authority, after public hearings, to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services. If the administrative director fails to adopt an official medical fee schedule for physician services by January 1, 2006, the existing official medical fee schedule rates for physician services shall remain in effect until a new schedule is adopted or the existing schedule is revised.

SEC. 36. Section 5307.2 of the Labor Code is repealed.

SEC. 37. Section 5307.2 is added to the Labor Code, to read:

5307.2. The administrative director shall contract with an independent consulting firm, to the extent permitted by state law,

to perform an annual study of access to medical treatment for injured workers. The study shall analyze whether there is adequate access to quality health care and products for injured workers and make recommendations to ensure continued access. If the administrative director determines, based on this study, that there is insufficient access to quality health care or products for injured workers, the administrative director may make appropriate adjustments to medical and facilities' fees. When there has been a determination that substantial access problems exist, the administrative director may, in accordance with the notification and hearing requirements of Section 5307.1, adopt fees in excess of 120 percent of the applicable Medicare payment system fee for the applicable services or products.

SEC. 38. Section 5307.21 of the Labor Code, as added by Section 74 of Chapter 6 of the Statutes of 2002, is repealed.

SEC. 39. Section 5307.21 of the Labor Code, as added by Section 13 of Chapter 866 of the Statutes of 2002, is repealed.

SEC. 41. Section 5307.27 is added to the Labor Code, to read:

5307.27. On or before December 1, 2004, the administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt, after public hearings, a medical treatment utilization schedule, that shall incorporate the evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission pursuant to Section 77.5, and that shall address, at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases.

SEC. 42. Section 5307.3 of the Labor Code is amended to read:

5307.3. The administrative director may adopt, amend, or repeal any rules and regulations that are reasonably necessary to enforce this division, except where this power is specifically reserved to the appeals board or the court administrator.

No rule or regulation of the administrative director pursuant to this section shall be adopted, amended, or rescinded without public hearings. Any written request filed with the administrative director seeking a change in its rules or regulations shall be deemed to be denied if not set by the administrative director for public

hearing to be held within six months of the date on which the request is received by the administrative director.

SEC. 43. Section 5318 of the Labor Code is repealed.

SEC. 44. Section 5318 is added to the Labor Code, to read:

5318. (a) Implantable medical devices, hardware, and instrumentation for Diagnostic Related Groups (DRGs) 004, 496, 497, 498, 519, and 520 shall be separately reimbursed at the provider's documented paid cost, plus an additional 10 percent of the provider's documented paid cost, not to exceed a maximum of two hundred fifty dollars ($250), plus any sales tax and shipping and handling charges actually paid.

(b) This section shall be operative only until the administrative director adopts a regulation specifying separate reimbursement, if any, for implantable medical hardware or instrumentation for complex spinal surgeries.

SEC. 45. Section 5703 of the Labor Code is amended to read:

5703. The appeals board may receive as evidence either at or subsequent to a hearing, and use as proof of any fact in dispute, the following matters, in addition to sworn testimony presented in open hearing:

(a) Reports of attending or examining physicians.

(1) Statements concerning any bill for services are admissible only if made under penalty of perjury that they are true and correct to the best knowledge of the physician.

(2) In addition, reports are admissible under this subdivision only if the physician has further stated in the body of the report that there has not been a violation of Section 139.3 and that the contents of the report are true and correct to the best knowledge of the physician. The statement shall be made under penalty of perjury.

(b) Reports of special investigators appointed by the appeals board or a workers' compensation judge to investigate and report upon any scientific or medical question.

(c) Reports of employers, containing copies of timesheets, book accounts, reports, and other records properly authenticated.

(d) Properly authenticated copies of hospital records of the case of the injured employee.

(e) All publications of the Division of Workers' Compensation.

(f) All official publications of the State of California and United States governments.

(g) Excerpts from expert testimony received by the appeals board upon similar issues of scientific fact in other cases and the prior decisions of the appeals board upon similar issues.

(h) Relevant portions of medical treatment protocols published by medical specialty societies. To be admissible, the party offering such a protocol or portion of a protocol shall concurrently enter into evidence information regarding how the protocol was developed, and to what extent the protocol is evidence-based, peer-reviewed, and nationally recognized, as required by regulations adopted by the appeals board. If a party offers into evidence a portion of a treatment protocol, any other party may offer into evidence additional portions of the protocol. The party offering a protocol, or portion thereof, into evidence shall either make a printed copy of the full protocol available for review and copying, or shall provide an Internet address at which the entire protocol may be accessed without charge.

SEC. 47. Section 6401.7 of the Labor Code is amended to read:

6401.7. (a) Every employer shall establish, implement, and maintain an effective injury prevention program. The program shall be written, except as provided in subdivision (e), and shall include, but not be limited to, the following elements:

(1) Identification of the person or persons responsible for implementing the program.

(2) The employer's system for identifying and evaluating workplace hazards, including scheduled periodic inspections to identify unsafe conditions and work practices.

(3) The employer's methods and procedures for correcting unsafe or unhealthy conditions and work practices in a timely manner.

(4) An occupational health and safety training program designed to instruct employees in general safe and healthy work practices and to provide specific instruction with respect to hazards specific to each employee's job assignment.

(5) The employer's system for communicating with employees on occupational health and safety matters, including provisions designed to encourage employees to inform the employer of hazards at the worksite without fear of reprisal.

(6) The employer's system for ensuring that employees comply with safe and healthy work practices, which may include disciplinary action.

(b) The employer shall correct unsafe and unhealthy conditions and work practices in a timely manner based on the severity of the hazard.

(c) The employer shall train all employees when the training program is first established, all new employees, and all employees given a new job assignment, and shall train employees whenever new substances, processes, procedures, or equipment are introduced to the workplace and represent a new hazard, and whenever the employer receives notification of a new or previously unrecognized hazard. Beginning January 1, 1994, an employer in the construction industry who is required to be licensed under Chapter 9 (commencing with Section 7000) of Division 3 of the Business and Professions Code may use employee training provided to the employer's employees under a construction industry occupational safety and health training program approved by the division to comply with the requirements of subdivision (a) relating to employee training, and shall only be required to provide training on hazards specific to an employee's job duties.

(d) The employer shall keep appropriate records of steps taken to implement and maintain the program. Beginning January 1, 1994, an employer in the construction industry who is required to be licensed under Chapter 9 (commencing with Section 7000) of Division 3 of the Business and Professions Code may use records relating to employee training provided to the employer in connection with an occupational safety and health training program approved by the division to comply with the requirements of this subdivision, and shall only be required to keep records of those steps taken to implement and maintain the program with respect to hazards specific to an employee's job duties.

(e) (1) The standards board shall adopt a standard setting forth the employer's duties under this section, on or before January 1, 1991, consistent with the requirements specified in subdivisions (a), (b), (c), and (d). The standards board, in adopting the standard, shall include substantial compliance criteria for use in evaluating an employer's injury prevention program. The board may adopt less stringent criteria for employers with few employees and for

employers in industries with insignificant occupational safety or health hazards.

(2) Notwithstanding subdivision (a), for employers with fewer than 20 employees who are in industries that are not on a designated list of high hazard industries and who have a workers' compensation experience modification rate of 1.1 or less, and for any employers with fewer than 20 employees who are in industries that are on a designated list of low hazard industries, the board shall adopt a standard setting forth the employer's duties under this section consistent with the requirements specified in subdivisions (a), (b), and (c), except that the standard shall only require written documentation to the extent of documenting the person or persons responsible for implementing the program pursuant to paragraph (1) of subdivision (a), keeping a record of periodic inspections pursuant to paragraph (2) of subdivision (a), and keeping a record of employee training pursuant to paragraph (4) of subdivision (a). To any extent beyond the specifications of this subdivision, the standard shall not require the employer to keep the records specified in subdivision (d).

(3) The division shall establish a list of high hazard industries using the methods prescribed in Section 6314.1 for identifying and targeting employers in high hazard industries. For purposes of this subdivision, the ''designated list of high hazard industries'' shall be the list established pursuant to this paragraph.

For the purpose of implementing this subdivision, the Department of Industrial Relations shall periodically review, and as necessary revise, the list.

(4) For the purpose of implementing this subdivision, the Department of Industrial Relations shall also establish a list of low hazard industries, and shall periodically review, and as necessary revise, that list.

(f) The standard adopted pursuant to subdivision (e) shall specifically permit employer and employee occupational safety and health committees to be included in the employer's injury prevention program. The board shall establish criteria for use in evaluating employer and employee occupational safety and health committees. The criteria shall include minimum duties, including the following:

(1) Review of the employer's (A) periodic, scheduled worksite inspections, (B) investigation of causes of incidents resulting in

injury, illness, or exposure to hazardous substances, and (C) investigation of any alleged hazardous condition brought to the attention of any committee member. When determined necessary by the committee, the committee may conduct its own inspections and investigations.

(2) Upon request from the division, verification of abatement action taken by the employer as specified in division citations.

If an employer's occupational safety and health committee meets the criteria established by the board, it shall be presumed to be in substantial compliance with paragraph (5) of subdivision (a).

(g) The division shall adopt regulations specifying the procedures for selecting employee representatives for employer-employee occupational health and safety committees when these procedures are not specified in an applicable collective bargaining agreement. No employee or employee organization shall be held liable for any act or omission in connection with a health and safety committee.

(h) The employer's injury prevention program, as required by this section, shall cover all of the employer's employees and all other workers who the employer controls or directs and directly supervises on the job to the extent these workers are exposed to worksite and job assignment specific hazards. Nothing in this subdivision shall affect the obligations of a contractor or other employer which controls or directs and directly supervises its own employees on the job.

(i) Where a contractor supplies its employee to a state agency employer on a temporary basis, the state agency employer may assess a fee upon the contractor to reimburse the state agency for the additional costs, if any, of including the contract employee within the state agency's injury prevention program.

(j) (1) The division shall prepare a Model Injury and Illness Prevention Program for Non-High-Hazard Employment, and shall make copies of the model program prepared pursuant to this subdivision available to employers, upon request, for posting in the workplace. An employer who adopts and implements the model program prepared by the division pursuant to this paragraph in good faith shall not be assessed a civil penalty for the first citation for a violation of this section issued after the employer's adoption and implementation of the model program.

(2) For purposes of this subdivision, the division shall establish a list of non-high-hazard industries in California, that may include the industries that, pursuant to Section 14316 of Title 8 of the California Code of Regulations, are not currently required to keep records of occupational injuries and illnesses under Article 2 (commencing with Section 14301) of Subchapter 1 of Chapter 7 of Division 1 of Title 8 of the California Code of Regulations. These industries, identified by their Standard Industrial Classification Codes, as published by the United States Office of Management and Budget in the Manual of Standard Industrial Classification Codes, 1987 Edition, are apparel and accessory stores (Code 56), eating and drinking places (Code 58), miscellaneous retail (Code 59), finance, insurance, and real estate (Codes 60–67), personal services (Code 72), business services (Code 73), motion pictures (Code 78) except motion picture production and allied services (Code 781), legal services (Code 81), educational services (Code 82), social services (Code 83), museums, art galleries, and botanical and zoological gardens (Code 84), membership organizations (Code 86), engineering, accounting, research, management, and related services (Code 87), private households (Code 88), and miscellaneous services (Code 89). To further identify industries that may be included on the list, the division shall also consider data from a rating organization, as defined in Section 11750.1 of the Insurance Code, the Division of Labor Statistics and Research, including the logs of occupational injuries and illnesses maintained by employers on Form CAL/OSHA No. 200, or its equivalent, as required by Section 14301 of Title 8 of the California Code of Regulations, and all other appropriate information. The list shall be established by June 30, 1994, and shall be reviewed, and as necessary revised, biennially.

(3) The division shall prepare a Model Injury and Illness Prevention Program for Employers in Industries with Intermittent Employment, and shall determine which industries have historically utilized seasonal or intermittent employees. An employer in an industry determined by the division to have historically utilized seasonal or intermittent employees shall be deemed to have complied with the requirements of subdivision (a) with respect to a written injury prevention program if the employer

adopts the model program prepared by the division pursuant to this paragraph and complies with any instructions relating thereto.

(k) With respect to any county, city, city and county, or district, or any public or quasi-public corporation or public agency therein, including any public entity, other than a state agency, that is a member of, or created by, a joint powers agreement, subdivision (d) shall not apply.

(*l*) Every workers' compensation insurer shall conduct a review, including a written report as specified below, of the injury and illness prevention program (IIPP) of each of its insureds within four months of the commencement of the initial insurance policy term. The review shall determine whether the insured has implemented all of the required components of the IIPP, and evaluate their effectiveness. The training component of the IIPP shall be evaluated to determine whether training is provided to line employees, supervisors, and upper level management, and effectively imparts the information and skills each of these groups needs to ensure that all of the insured's specific health and safety issues are fully addressed by the insured. The reviewer shall prepare a detailed written report specifying the findings of the review and all recommended changes deemed necessary to make the IIPP effective. The reviewer shall be an independent licensed California professional engineer, certified safety professional, or a certified industrial hygienist.

SEC. 48. The Commission on Health and Safety and Workers' Compensation shall conduct a study of the spinal surgery second opinion procedure established in subdivision (b) of Section 4062 of the Labor Code. The study shall be completed by June 30, 2006. The commission shall issue a report concerning the findings of the study and recommendations for further legislation.

SEC. 49. Section 9792.6 of Title 8 of the California Code of Regulations is repealed effective January 1, 2004.

SEC. 50. Article 7 (commencing with Section 70) of Chapter 1 of Division 1 of the California Code of Regulations is repealed effective January 1, 2004.

SEC. 51. On January 1, 2004, all assets and liabilities of the Industrial Medical Council, the Industrial Medicine Fund, and any unencumbered funds available pursuant to Schedule (4) of Item 7350-001-0001 and Items 7350-015-0223 and 7350-001-0079 of the Budget Act of 2003 shall be transferred to the Workers'

Compensation Administration Revolving Fund established in Section 62.5 of the Labor Code.

SEC. 52. The regulations adopted by the Industrial Medical Council contained in Chapter 1 (commencing with Section 1) of Division 1 of Title 8 of the California Code of Regulations, except for those regulations repealed in Section 50 of this act, shall remain in effect and shall be deemed to be regulations adopted by the Administrative Director of the Division of Workers' Compensation. The terms of all qualified medical examiners appointed by the Industrial Medical Council shall be unaffected by the changes made by this act. All qualified medical examiners appointed by the Industrial Medical Council shall be deemed to be appointments made by the Administrative Director of the Division of Workers' Compensation. Any pending disciplinary actions against qualified medical examiners shall not be affected by the changes made by this act.

SEC. 52.5. (a) The Legislature finds and declares all of the following:

(1) The State Compensation Insurance Fund is the workers' compensation insurer of last resort insuring most of the small employers in the state, and employers that cannot find insurance elsewhere.

(2) Today, the State Compensation Insurance Fund covers over 50 percent of the market and its financial health is essential to the economic well-being of the state.

(3) Employers in this state need reasonably priced workers' compensation insurance.

(b) It is the intent of the Legislature that the Insurance Commissioner review and analyze the financial condition, underwriting practices, and rate structure of the State Compensation Insurance Fund and report to the Legislature and the Governor on the potential of reducing rates by July 1, 2004, and every July 1 thereafter.

SEC. 53. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 54. This act shall become operative only if Assembly Bill 227 of the 2003–04 Regular Session is enacted and becomes operative.

SEC. 55. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Approved _____, 2003

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Governor